younger. Only by drastic changes such as these will the manpower problem be solved in a way that the standard of consultant, and indeed specialist practice, in this country be maintained.

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Medical unemployment

SIR,—Janice Luby (7 August, p 442) queried the motives of those principals in practice who prefer to appoint a partner of 35 or under, and asked what the BMA's attitude is to "age discrimination." The bland reply from the secretary that "the BMA gives no guidance" is distinctly unhelpful. It is time the Association at least voiced disapproval of discriminatory practices.

Discrimination on grounds of age makes even less sense than that on grounds of sex, race, or religion. To restate the obvious, a good GP may be old or youngish, black or white, man or woman, and so may a bad GP. What matters far more is experience, compassion, and a liking for people, and of these the first is directly related to age. Many late entrants to general practice have a wealth of previous experience which is useful. The life-experience of late entrants to medicine may be a great help in communicating with patients, as I have frequently found. Indeed, youth can be a handicap which fortunately is soon outgrown.

Mrs Luby can take comfort from the fact that others in the same precarious position as her husband are even older. I do not doubt that the compensating advantages of being over 35 will be recognised by the discriminating potential employer.

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Chiropody and podiatry

SIR,—I am reluctant to enter into public controversy with Mr M G Paynton, press officer of the British Chiropody Association, but feel obliged to respond to a number of the points made in his letter (14 August, p 515).

Mr Paynton states that no claims for malpractice have been upheld against unregistered chiropodists in 25 years. I regret to have to inform him that in March this year the Queen's Bench Division of the High Court of Justice awarded damages of £5232·71 and costs against an unregistered chiropodist. This award is substantially in excess of any award which has been made against a member of this society under our third-party professional indemnity insurance policy.

I must refute the statement that the Society of Chiropodists has made no valuable contribution to foot care. This society is the only recognised examining body for the purpose of State registration of chiropodists in Britain. It publishes a monthly professional journal and regularly arranges professional meetings throughout the UK, whether they be branch meetings, one-day conferences, or an annual convention. The society is involved in postgraduate education, and many of its members are also members of postgraduate groups. It publishes a number of foot health leaflets and posters and has collaborated with the Health Education Council over a number of foot-care publications.

Mr Paynton claims that the society is a minority body. All I can state is that according to the 1971 census approximately 6000 persons described their occupation as "chiropodists." As at the end of June there were 5220 chiropodists on the State register. The number of society members on 31 December 1981 was 4696.

While all the chiropodial members of the Chiropodists Board are at present members of this society, those in the profession who are aware of the current "political" situation, will also know that in no way can it be said that the society has a monopoly of the Chiropodists Board which is a statutorily independent organisation.

I am pleased to confirm that, like the BMA, this society is a company, limited by guarantee with a licence to dispense with the term "limited" from its title, and a registered trade union with a certificate of independence. As a trade union, the society represents its members on the Whitley Professional and Technical "A" Council staff side. I note that the British Chiropody Association has no comparable status.

Mr Paynton fails to state that the majority of the members of his association will have undertaken correspondence courses, followed in some cases by a short period of practical tuition by an unregistered chiropodist, and that their training does not qualify his members either for membership of this society or for State registration. The course of training recognised by this society for the purpose of membership and by the Chiropodists Board for the purpose of State registration in the United Kingdom is a three-year full-time course of training followed by a final professional examination in which medical examiners approved by the Royal College of Surgeons, the Royal College of Physicians, and the Faculty of Anaesthetists participate.

I am glad to note that Mr Paynton agrees that unqualified persons should not be allowed to practise chiropody, and I would hope therefore that his association will now be prepared to support the case for closure of the profession.

Finally, as far as the relationship between this society and the British Orthopaedic Association is concerned, I am pleased to report that in March this year the society received a letter from the president of the British Orthopaedic Association stating that "the present relationships between our associations are indeed cordial."

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More consultants, fewer juniors

SIR,—Despite the Short Report on medical education and the proposals from the Central Committee for Hospital Medical Services (22 May, p 1575) there have been few data on improving medical manpower imbalances. A useful contribution was, however, provided by Dr David T Jones and Dr R Sampangi Ramaiah (24 July, p 319). Funding has not been forthcoming for expanding the consultant grade, yet the output of doctors from medical schools has increased. The CCHMS's response was clearly an attempt at a rescue operation, which was passed by the Annual Representative Meeting but only as a reference to the BMA Council.

A short-term solution to alleviate the present bottleneck of fully trained staff at senior registrar level is desirable. The simple solution is to offer early retirement to consultants at 60, or even 55, without loss of pension rights. This would create vacancies for fully trained staff and alter the staffing ratio of juniors to consultants. Long-term solutions should also be planned. Let us suppose that all registrars expect to become consultants; that consultants are appointed at 39 and retire at 60; that registrars are appointed at 30; that they spend part of their time as middle-grade registrars and part as senior registrars. Let it be supposed further that all registrar posts are in district general hospitals which serve a total of X beds, and that all senior registrar posts are in university teaching hospitals which serve a total of Y beds. The construction of a mathematical model is then quite simple. The proportion of middle-grade registrars to senior registrars should be in the ratio of X to Y, and the time spent in each grade should be in the ratio of $X/X+Y$ to $Y/X+Y$. For example, if district general hospital and university teaching hospital beds are in the ratio of eight to one then the ratio of middle-grade registrars to senior registrars should also be eight to one and 8/9 of the time would be spent as a middle-grade registrar and one-ninth as a senior registrar.

The ratio of consultants to registrars—that is, middle-grade registrar plus senior registrar—should be related to the number of years spent in the grade. (It is assumed that there are no losses due to emigration or death; adjustment of the mathematical model could be made for this.) Registrars should spend nine years in the grade and consultants 21 years. The number of consultants and registrars should therefore be in the ratio of 21 to nine. If there is a similar proportion of consultant staff in relation to beds in district general hospitals and in university teaching hospitals, this implies a ratio of consultants to registrars of seven to three, both in university teaching hospitals, where there are senior registrars only, and in district general hospitals where there are middle grade registrars only. (Without early retirement the appropriate ratio would be about nine to three.) The three implies a one-in-three duty rota. Less would make the job too busy by present standards; more would give insufficient experience. It also implies a fairly large district, big enough to require seven consultants and three registrars.

It is wasteful to train doctors to senior registrar level and not to appoint them to consultant posts. Thirty-nine has been the average age of appointment of consultant general surgeons for some time. It is difficult to see how the average age could be greatly lowered without eroding standards. It is more difficult to see how the training time in years could be reduced at the same time as the time off each week is increased. The present retirement age is too great if consultant-to-registrar ratios are to be reduced. Reduction from 65 to 60 is equivalent to a 5/26 or nearly 20% increase in the number of consultants.

Appointment of registrars at 30 would give them time to obtain a higher qualification or to change to another specialty. Allocation of all middle-grade registrar posts to district general hospitals and all senior registrar posts to university teaching hospitals ensures that middle-grade registrars get good practical experience at district general hospitals, where most of them will eventually become consultants, that there is fairness in distribution of registrars and senior registrars in relation to the number of beds, and that there is equality of opportunity in appointment to senior registrar posts. These assumptions are given for a consultant general surgeon but will, of course, differ for other specialties.

There will be many views about the assumptions and much argument about the final ratios. My purpose is to emphasise that the solution cannot be considered until calculations have been made.

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